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Justify It! Ultralightweight Chairs

Clinically, K0005 wheelchairs can offer clients a wealth of benefits, from improved propulsion efficiency to less wear on upper extremities over a lifetime of use. But how do you get payors to agree? Here’s how to turn your observations, measurements and data into a claim that gets paid!

Early-Intervention Power: Who Can Participate?

Are there prerequisite skills for very young children who could be candidates for power mobility? Should there be? And are grown-ups’ expectations getting in the way of kids’ potential independence?

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What’s New Online: MobilityMgmt.com & TheMobilityProject.com

MobilityMgmt.com has a brand-new, easier-to-navigate design to help seating, mobility and accessibility professionals quickly find the news, feature stories and resources they want. And now, TheMobilityProject.com, our consumer/caregiver-targeted site, is accessible via the MM site. On the main navigation bar, just click on the “Consumers” button to go to the consumer site; then click the “Professionals” button to return to MM!

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editor’s note

A New Strategy for a New Year

We learn as kids that the best way to resolve disagreements is to work directly with the other party. Whether it’s an argument over who is up next in kickball or who is responsible for which part of a group science project, we are urged to talk it out amongst ourselves without hollering for Mom or Teacher, or later in life, without calling in the boss.

It’s a sound and efficient strategy for many of life’s everyday situations. But its effectiveness hinges on one requirement: Everyone must be committed to working the situation out. If a key player doesn’t want to, we’re left with an “I’m taking my kickball and going home” mess.

So seems the case with complex rehab technology (CRT) stakeholders and the Centers for Medicare & Medicaid Services (CMS). On one side are assistive technology manufacturers, clinicians, consumers and caregivers. On the other are the people who decide whether that assistive technology gets into the lives of the beneficiaries who need it.

Theoretically, there shouldn’t be two sides. Everyone on the list is by definition on the same side, just at different positions along the line: end user of the product, prescribers of the product, fitters and builders of the product, manufacturers of the product, funders of the product.

And ideally, when differences arise — and they will, and that’s okay — everyone should be able to pool their thoughts, ideas and concerns, debate them, and work out a solution.

The discouraging thing about CMS’s capped-rental final rule is that the public comment process has worked before. Remember the power mobility device prior authorization demonstration project going on in seven states? That started out as a prepayment review (phase 1) and prior authorization (phase 2) demonstration, but after receiving and hearing public comments, CMS ditched phase 1 and launched the demo with just the prior authorization portion in place.

The result? By and large, a program that is doing what CMS wanted without crippling beneficiary access to the equipment or driving power chair providers out of business.

So it can be done. We’ve seen it happen. But this time through, CMS asked for public comment seemingly only because it’s forced to do so. It seemed less a call of “We want feedback from everyone about the most” than “We’re legally obliged to request comments, so we will wait the required number of days before releasing our rule the way we’ve already decided it should be.”

In the past when this has happened, a common industry response has been “We need to provide more education.” The theory is that if people really knew what complex rehab technology is, what it can do, how little of the Medicare budget it costs, etc., they would make different decisions. Armed with knowledge, they would use it.

Again, it’s sound theory. But only if everyone is still pulling for a mutually beneficial outcome. Don Clayback, executive director of NCART, says in this issue’s CMS Update column (page 24) that he personally no longer believes CMS’s decisions are the result of not understanding what CRT is. In fact, the reason that CMS is making decisions that make no sense to us — or to Veterans Affairs or consumer organizations or clinicians — may be because CMS has a different agenda than what we’ve assumed it had.

If that’s the case, Don suggests, our reactions need to change accordingly. For my part, I’ve started logging the numbers and nature of the consumer phone calls and e-mails I receive every week from caregivers and beneficiaries desperate to get a wheelchair fixed or a new chair funded. I’m turning over the info to Don so he has it when he takes his meetings to the next level.

It may be the only level the industry has left, judging from the way CMS is refusing to play ball.
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Japanese Power Chair Makes Its American Debut in San Jose

A new Japanese power wheelchair that made its American debut in San Jose, Calif., during the November Abilities Expo should be ready for delivery early next year, its manufacturer says.

The WHILL is a four-wheeled power chair created by a team of Japanese engineers with, according to their Web site, product development experience at major consumer electronics firms, including Olympus and Sony.

The chair’s calling card is its special front-wheel design that enables the vehicle to turn in its own space. The WHILL team refers to the design as a “special all-around wheel.”

The WHILL’s front wheel has the same general shape as traditional wheelchair wheels. But instead of tires, it has rollers that cross from one side of the wheel to the other. Those rollers give the front wheels the ability to turn in multiple directions, much like a ball bearing.

The WHILL is also steered differently, via lever-like arms that extend diagonally from the sides of the chair (and serve as the user’s armrests). The arms can be moved out of the way for transfers and to enable users to fit under desks or tables. WHILL’s team says the chair can be driven with either the user’s left or right hand.

“All you need is a good command of your wrist and a little strength in your thumb and index finger,” the WHILL Web site says. “Control is very intuitive, just like an ordinary joystick.”

The chair has a top speed of 6 mph and a user weight capacity of 300 lbs. Its team says it’s capable of navigating 10° slopes, weighs 176 lbs., and can climb obstacles up to 3” high.

In correspondence with Mobility Management, Atsushi Mizushima, WHILL’s co-founder and director of business development, said of the new power chair, “We reflected the real voices of hundreds of mobility device users through the interviews and test drives with our previous prototype. WHILL provides everyone with more independence and style.”

WHILL’s team has raised $1.7 million so far, Mizushima added, to fund the chair’s development.

As for meeting with consumers at the San Jose event the week before Thanksgiving, Mizushima said after the opening day, “We received so many good reactions!” Future WHILL appearances are scheduled for the Consumer Electronics Show (CES) in Las Vegas in January and the Abilities Expo in Los Angeles in late February. To see videos of the WHILL in action, go to youtube.com and search “WHILL.” For more product info, visit whill.jp.

“We will work hard,” Mizushima said, “to provide people with good and viable products, more independence and style.”

Consumers at the San Jose Abilities Expo took the new WHILL power chair for a spin. Photos courtesy WHILL Inc.
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Market Trends

Report: Pressure Relief Market Will Top $4 Billion by 2019

Pressure ulcers are a debilitating problem for a number of consumers with limited mobility — and it’s a medical problem that will drive growth in the pressure-relief device market in the years to come, according to a new report from GBI Research.

The report is called “Pressure Relief Devices Market to 2019: Increasing Focus on Pressure Ulcer Prevention & Quality of Care to Drive Growth.”

The report examined pressure-relieving mattress overlays, specialty beds (both purchased and rented) and mattresses.

In 2012, the size of that market was $2.9 billion. GBI estimates that by 2019, the market size will stand at $4.1 billion, and predicts a compound annual growth rate of 4.7 percent.

“Previous research shows that more than 2.5 million Americans are expected to develop this condition every year,” GBI Research said about pressure ulcers in a news announcement. “The rising prevalence of obesity will also drive the pressure relief devices market growth. Obese patients are at an increased risk of developing pressure ulcers, as they are required to stay in hospital for longer periods and have slower wound-healing times.”

Challenges for the pressure-relief market, according to GBI Research, include the relatively high costs of treating pressure ulcers and corresponding lack of reimbursement for pressure-related products.

Srikanth Venkataraman, a GBI Research analyst who worked on the report, added, “U.S. Medicare does not provide reimbursement for the treatment of hospital-acquired pressure ulcers.” Nevertheless, Venkataraman believes pressure sore prevention should remain an important goal for caregivers:

“As pressure ulcers cause pain and increase the risk of skin infection, caregivers should focus on protecting patients from high-risk pressure sores using appropriate prevention strategies. These include pressure-relieving support surfaces, such as bariatric beds with multiple functionalities.”

GBI Research provides business intelligence reports for a number of global industries, including medical devices, pharmaceuticals and healthcare, and clean technology. GBI Research has offices in Europe, Asia and North America.

The organization says the statistics quoted in the report do not include wheelchair seat cushions designed to lower the risk of developing pressure ulcers.

USA Cares Honors Pride Mobility for Supporting Military Families

USACares, a non-profit organization that advocates for post-Sept. 11 American military families, has recognized Pride Mobility Products for its support.

Dick McLane, Pride’s GM of product marketing, sits on the USA Cares board; and Bryan Anderson, Quantum Rehab spokesperson and Purple Heart recipient, frequently works on behalf of USA Cares’ efforts.

“Our goal with USA Cares is to not only provide vital financial support to service members in need, but to also show others that you can go through a profoundly life-changing event and thrive,” Anderson said in a news announcement. Anderson, a triple amputee, was injured in 2005 during his second tour in Iraq, and was among the Pride Mobility representatives accepting the award on behalf of the manufacturer.

“We value the company and want them to know they are making a difference in the lives of veterans and their families,” said USA Cares President Peter Giusti during the award presentation.
briefly...

A scheduling heads-up from the management team of Medtrade Spring 2014: The event runs Monday through Wednesday, March 10-12, instead of the usual Tuesday-through-Thursday timing. The exhibit hall is open March 11-12 at the Mandalay Bay Convention Center in Las Vegas. To register or peruse the educational offerings, go to medtrade.com. In more 2014 event news, don't forget to add the VGM Group’s Heartland Conference to your calendar. The June 9-12 gathering in Waterloo, Iowa, is called, “Define Your Future.” And to make travels even easier for providers, VGM is offering free shuttle service from the Cedar Rapids (Eastern Iowa) airport! Registration opens Feb. 1. In a new report issued by CareerCast, a job-search Web site, occupational therapist was listed as the third-best job in the healthcare segment for 2013, with physical therapist at number five and medical records technician at number 11. Life Rolls On founder Jesse Billauer has announced that the foundation has ended its subsidiary affiliation with the Christopher & Dana Reeve Foundation. Billauer has become Life Rolls On’s executive director/CEO. The organization’s goal, Billauer says, is to improve “the quality of life for young people affected by spinal cord injury, utilizing action sports as a platform for inspiring infinite possibilities beyond paralysis.” Life Rolls On, established in 2002, is best known for its They Will Surf Again program. A new and surprising report from Johns Hopkins showed longer life expectancies for people who acted as caregivers for family members. The study reported an 18-percent “survival advantage” for caregivers compared to non-caregivers of the same age. The report, published in the American Journal of Epidemiology, suggests that the caregivers studied experienced improved self-esteem and appreciated the gratitude of the loved ones they were caring for, which may have positively impacted their life expectancies. But researchers pointed out that for the benefits to take place, the stressful aspects of caregiving had to be well managed. Congratulations to Eric Kolacinski, who has been named area VP of Home Health Depot’s complex rehab division. Kolacinski, a rehab veteran, founded Pinnacle Rehab in Chicago in 2007, eventually selling it to United Seating & Mobility and serving as a Midwestern VP for Numotion. Home Health Depot has 17 offices in Georgia, Illinois, Indiana, Iowa, Michigan and Texas.
Home Care Medical Launches Web Site Redesign

Home Care Medical has unveiled a newly redesigned Web site that seeks to educate everyone along the DME and complex rehab technology spectrum.

The new site (homecaremedical.com) highlights and explains the provider’s five major business segments: complex rehab technology, durable medical equipment, bracing and compression garments, home infusion, specialized nutrition and hospice care, and respiratory care. Visitors can read about the various services and equipment that Home Care Medical specializes in.

But the site also aims to be a resource for healthcare professionals, including referral sources. In their section, they’ll find guidelines on Medicare and Medicaid policies; information on Medicare’s competitive bidding program; education on Medicare’s upcoming face-to-face requirement for many types of DME; and the new PECOS registration requirements for prescribing Medicare physicians.

“As we continue to develop the Home Care Medical brand, we are pleased to launch our redesigned Web site,” said Home Care Medical VP of Sales & Marketing Kandy Raether in a news announcement.

“Packed full of educational materials, homecaremedical.com will be a resource to many of our customers and patients. In addition, with all of the new healthcare rules and guidelines that have been introduced to our industry, our Web site will be a ready reference for our referral sources.”

Home Care Medical is headquartered in New Berlin, Wisc., and has served southeastern Wisconsin since opening in 1974. Home Care Medical also has retail offices in Milwaukee, Sheboygan and West Bend, Wisc.

Invacare Equips Youth Challenge Power Soccer Team

It’s never too early to start training for Rio — and beyond! Thanks to a donation from Invacare Corp., a new Youth Challenge (YC) power soccer team in Westlake, Ohio, has begun that journey.

Invacare donated eight Pronto M51 power wheelchairs that were fitted with bumpers donated as part of a Northern Ohio Golf Charities grant.

“Power soccer gives many of the children at YC a unique opportunity to play a competitive team sport,” said Chris Garr, YC director of program services in a news announcement. “Thanks to the generosity of Invacare, children who utilize power wheelchairs can now join a team, learn a skill and partake in friendly organized competition.”

Jud Cummins, Invacare’s business manager for powered mobility, was present to watch the premiere four-on-four power soccer match. “The kids here are fantastic,” he said. “A lot of them use Invacare mobility products in their everyday lives. It was a natural connection between Invacare and our mission of making life’s experiences possible, and Youth Challenge who carries out that mission through great programs like power soccer and many other sports.”

Youth Challenge said formal training will start this summer for the 2016 Rio de Janeiro, Brazil, Paralympic team.
Quickie IRIS at 10: Sunrise Celebrates a Decade of Tilt-in-Space History

It’s become such an indispensable part of complex rehab that it’s sometimes hard to believe that tilt-in-space technology hasn’t always been a seating & positioning option.

But it’s true, and believe it or not, Sunrise Medical’s Quickie IRIS wheelchair — an acronym for Intelligent Rotation in Space — has celebrated its first 10 years in production.

In an announcement about the milestone, Brent Hatch, director of product management, said, “The IRIS has been a leader in tilt technology since its introduction in 2003. It continues to evolve and improve as we identify better ways to address user and caregiver needs and as wheelchair technology becomes more advanced.”

Sunrise notes that the IRIS eliminated gas springs for tilting and “boasted smooth, balanced rotation over a compact wheelbase.”

IRIS was updated in 2008, 2010 and 2013 with features such as cable-free tilting, a 6-lb. weight reduction, lower seat heights, Dynamic Back, angle-adjustable push handles and swing-in/swing-out hangers.

But Sunrise says the IRIS’s claim to fame has stayed the same: “Rotating the seat frame around the user’s center-of-gravity creates the most comfortable and secure tilting motion for the user, requires the least amount of effort from the caregiver, and allows for the shortest possible wheelbase for easy maneuverability.”

Hatch added that the milestone birthday is still just the start: “We’re looking forward to making it even better in the next 10 years.”

IRIS Video Aims at Next Generation of Users

Despite its tenure, the Quickie IRIS is still new to some, including consumers and caregivers unfamiliar with tilt-in-space technology. So as part of its 10-year anniversary efforts, Sunrise Medical created an IRIS video called, “Meet Jane, Super Caregiver.”

In less than three minutes and via whiteboard-style animation, the film tells of intrepid Jane, who seeks a better wheelchair for her daughter, Carol. Jane tells Richard, her ATP, that they need a chair that maneuvers well, that doesn’t startle Carol out of her sleep while tilting at night, that’s transit compatible with “No more vaulting onto the push handles to initiate tilt.” And: “I want a chair that’s safe. Not front tippy, not rear tippy. Safe, Richard.” (That last point is emphasized by a pair of animated crocodiles.)

The film is a fun and friendly way to learn about the IRIS and tilt-in-space concepts in general. Go to the sunrisemedical.com and check the IRIS video gallery to view it.

— Laurie Watanabe
The calling card of the ultralightweight manual wheelchair (HCPCS code K0005) is indeed its very light weight. Thanks to the best materials (top-grade titanium and aluminum) and the best engineering practices and designs, many of today’s K0005 frames weigh far less than 20 lbs. Their high-level performance and their sleek good looks make ultralightweight chairs much revered and sought after by active full-time wheelchair users.

Ultralights are also admired by the ATPs and clinicians who work with those consumers. K0005s can offer customized fit and configurability unmatched by other manual wheelchair types (see sidebar), which occupational and physical therapists certainly appreciate when working with clients who have complex seating & mobility needs. On the funding side, however, ultralight chairs can be a challenge to get approved by payors who would rather pay for less expensive, less adjustable and less fully featured equipment…and scrutinize K0005 claims accordingly.

Therefore, the seating & mobility team has to do more than just think about a K0005 in terms of clinical need. The team also needs to document that need well enough to satisfy the funding source.

**K0005 Clinical Considerations**

What clinical issues might lead a clinician or ATP to consider assessing a client for an ultralight chair?

Tina Roesler, MSPT, ABDA, director of education and international sales for TiLite, notes the importance of getting a good client history and says key questions include, “Does the client have a history of upper-extremity pain or dysfunction? Is the client experiencing any pain with propulsion currently?”

Asked which mobility-related diagnoses might signal a need for an ultralight chair, Steve Boucher, OTR/L, ATP, clinical educator for Sunrise Medical, says, “Personally, I do not focus as much on diagnosis as I do on clinical presentation. However, individuals with paraplegia, higher-level quadriplegia, hemiplegia, multiple sclerosis, brain injury or those with developmental disorders such as cerebral palsy, spina bifida and muscular dystrophy can maximize their independence with the use of a K0005 mobility base.”

Roesler agrees that using diagnoses to choose a chair isn’t the best strategy: “Every client is different, and really, I don’t believe selection of an ultralight chair should be solely driven by diagnosis. The important piece is the client’s functional potential and the long-term goals that have been determined in therapy. If the client has the motivation and the functional capacity to self propel, an ultralight is appropriate.”

**Justifying Those Clinical Needs**

Once you’ve determined that the K0005 frame will meet your client’s needs, the second challenge begins: convincing your funding source.

Lois Brown, MPT, ATP/SMS, director of clinical operations & education for National Seating & Mobility, says it’s important from the start to establish how an ultralight — compared to a less-adjustable chair — will significantly improve the client’s ability to perform at least one mobility-related activity of daily living: toileting, bathing, feeding, dressing or grooming. Documentation needs to specifically
involve performing an MRADL, rather than just the client’s ability or inability to get to the kitchen or bathroom.

So Brown says documentation could describe specific adjustments to the ultralight frame that would significantly impact MRADL performance, decrease pain using a pain scale rating, reduce the need for pain medication due to improved chair configuration, or enable full-day wheelchair use versus frequent rests. While the client may have sufficient strength and range of motion for manual wheelchair propulsion, Brown says clinicians should note cardiac or respiratory issues when the weight or configuration of an ultralight frame could make a difference versus less-adjustable frames.

“Ultralights are prescribed when end users are unable to or have increased difficulty propelling a lower-coded chair due to clinical deficiencies such as a compromised cardiopulmonary system, upper-extremity (UE) weakness, a decrease in UE range of motion, decreased endurance for propulsion, spasticity, pain with propulsion, and orthopedic deformities,” Boucher says. “In some situations, the client’s ability to transfer to and from their wheelchair requires a lower or higher seat-to-floor height that K0001-K0004 chairs cannot offer.”

Know Your Products
Being able to offer data about how a client could benefit from a K0005 — such as how he says his shoulder pain decreases from a score of 7 to 1 when propelling an ultralight — requires understanding how the ultralight differs from lower-coded chairs, particularly the high-strength, lightweight K0004 chair.

Key points to remember about the K0005:
- **Rear-axle adjustability:** This is the K0005’s ultimate distinction for clinicians and ATPs who need to dial in a chair to very exacting and unique specifications for complex rehab clients.
  
  “The adjustable axle plate allows for center-of-gravity (horizontal shift), seat-to-floor height (vertical shift), camber, and lateral axle spacing (inward or outward) adjustments,” Boucher says. “These adjustments offer a tremendous benefit to our end users when implemented correctly.”

  Brown points out that K0004 chairs have some ability to adjust, but at a price: “You can change a K0004 to have a lower rear seat-to-floor height than front, but you need to change the rear wheel and the casters to accomplish that, which affects the ability of the chair to roll efficiently. So when I want to achieve a lower rear seat-to-floor height than the front, that’s a critical feature of the K0005. I’m able to accomplish it without changing the roll of the chair.”

- **Seat back options:** “There’s also seat-to-back angle adjustment and back height specificity,” Brown says. “If you use a K0004 and that back’s too high, it can push the shoulders forward, which changes the biomechanics of the upper body and also affects the client’s ability to efficiently propel and, again, complete their daily activities.”

- **Weight:** This is probably the most popular factor among consumers, and it’s true: Ultralight frames can weigh far less than lower-coded ones. The key, however, is to underline the importance of that weight savings by tying them back to those MRADLs. “[K0004s] are supposed to be less than 34 lbs., but you can have a K0005 that weighs significantly less,” Brown points out. “Remember the weight of the total system you’re creating. If you start with 33 lbs. and you add a 5-lb. cushion and a 4-lb. back, then you have to look at the effect on the person’s propulsion abilities based on the total weight of the chair. If you start high, based on what you have to add, obviously propulsion efficiency is decreased, there’s more respiratory demand, there’s more fatigue, the whole system is heavier for pushing.”

  “Advancements made with implementing 7000-series aluminum in K0005 frames have further provided benefit to end users, as these frames can reduce the weight of a wheelchair significantly,” Boucher says.

- **Precision configurability:** As mentioned, the K0005 isn’t the only type of manual chair capable of being adjusted. It stands alone, however, in its wide range of adjustability.

  “Study after study shows the importance of made-to-measure chairs in relation to maximizing function and preventing upper-limb injuries,” Roesler says. “Ultralight chairs are more adjustable, lighter weight, and overall more efficient to propel. While Medicare focuses on the ability to change rear wheel position as a differentiating factor — it is much more than that. The ability to change rear-wheel position for optimal propulsion is extremely important, but the type and amount of adjustment is, too.”

  Roesler explains that for complex rehab consumers, seemingly minute adjustments can make a huge functional difference. “For some people, proper configuration means moving the axle forward 1/2”.

  While some lightweight chairs might offer one or two rear wheel positions, you really aren’t able to fine-tune or optimize for the individual. You also tend to have more options available for critical components, such as rear wheels, handrim, front wheels, tires, and frame sizes and geometry. All of these options will help maximize someone’s functional potential.”

  In other words, it’s not just an optimized configuration, but also improved ride that can make the K0005 a much better choice for the full-time self-propeller.

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<thead>
<tr>
<th>Manual Chair HCPCS Codes</th>
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<tbody>
<tr>
<td>K0001: Standard manual wheelchair</td>
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<tr>
<td>K0002: Standard hemi-height manual chair</td>
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<td>K0003: Lightweight manual chair</td>
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<td>K0004: High-strength lightweight manual chair</td>
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<td>K0005: Ultralightweight manual chair</td>
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<td>K0006: Heavy-duty manual chair</td>
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<td>K0007: Extra heavy-duty manual chair</td>
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Source: cms.gov
“Availability of suspension systems as an option on K0005 chairs can help maximize the client’s sitting tolerance and utilization of their chair throughout the day,” Boucher says. “When propulsion of a chair without suspension causes undesired tonal reflexes, an elevation in pain or discomfort, or increased fatigue from maintaining functional sitting postures.”

Knowing the differences between types of chairs is critical to the documentation process. Brown says, especially for Medicare: “You must document in the letter of medical necessity and rule out the lesser device and why it does not have the features that will meet your patient’s needs in order for them to complete MRADLs. This is a best practice to justify your recommendations, regardless of payor source.”

It’s also important to know the features and benefits of individual products within the K0005 HCPCS code. Brown says.

“Therapists need to understand the differentiating features between the levels of products and also between the products themselves so that they can work with the RTS and the ATP on product selection,” she says. “The story begins with the therapist’s responsibility to first identify what are the patient’s problems, what are some potential solutions, what are some of the key critical features that you need to make sure that equipment has in order to solve the patient’s problem?”

“When you go to actual product selection. You should be able to think through the different levels of features offered by a K0005 and match them to the person’s geometry and clinical factors, like respiratory and cardiac issues, effects on spasticity, and postural stability.”

**Tools & Facts That Can Help**

The justification for a K0005 initially sounds quite straightforward. “If you simply review the evidence, it is clinically justified that any client who uses a manual wheelchair for independent manual mobility should be considered for an ultralight chair,” Roessler says. “The RESNA position paper on ultralight mobility also supports this.”

But from there, the process gets more complex — as does the need for the ATP and clinician to back up their professional opinions and choices with plenty of facts.

“Documentation should include the client’s functional potential, such as data related to wheelchair propulsion that can be gathered with tools like the SmartWheel and other clinical assessment tools,” Roessler notes. “If you have tried or are tracking multiple wheelchairs, be sure to include this in the justification and tell the funding body that you have tried other categories of equipment and why they don’t work.”

Prashant Srinivasan, described as the driver of sales for Out-Front’s SmartWheel, says, “Including actual data is important because it adds an extra dimension of evidence to back up the justification argument that’s being made. Justification arguments will always be stronger if they are backed up by both subjective statements and objective data.”

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### Justify ‘em: K0005s for Kids

Researc on kids, ultralightweight wheelchairs and propulsion is limited to date, but still plays an important role in how Lauren Rosen, PT, MPT, MSMS, ATP/ SMS, approaches her documentation work as program coordinator for the Motion Analysis Center at St. Joseph’s Children’s Hospital of Tampa.

“I treat a pediatric wheelchair the same way that I treat an adult wheelchair in that I still submit [claims] with an average of seven or eight peer-reviewed articles referenced in there,” she says.

Rosen uses research regarding adult ultralight usage based on the fact that a study published in the journal for the American Academy of Physical Medicine & Rehabilitation “basically comes to the conclusion that pediatric propulsion and adult propulsion are the same — the kinematics of it. I use the same information to justify a pediatric chair that I do for adults. I talk about the research that the longer that you use a chair, the more likely you are to suffer shoulder and other upper-extremity problems. I talk about the higher the weight of the person in the chair, the more chance of having median nerve compression and other injuries. I use a lot of the same information that I would put on my submission for an adult chair in those pediatric submissions.”

In addition to that background sort of material, Rosen has included information on:

- **Wheelchair weight relative to the child:** “I do talk about if we were to get some of the other kinds of chairs, that the chair itself would weigh more than the child weighs. I take pictures of the kid on the scale with the weight [visible]. I try to make it as obvious as it can be.”

- **Overall weight of the mobility system:** “I do also discuss what I’m putting on the chair; the weight of what I’m putting on the chair — lighter-weight cushions; if I can, I go with a back with basic upholstery if he’s got enough trunk for that; or if he needs more support, staying with as lightweight options as I can and pointing out to my funding sources that I’m picking this because of its light weight.”

  - **K0005 adjustability:** “I need to dial it in just as I would for any full-time adult chair user. I need that axle adjustability — especially as the kid grows, I need the ability to move that axle where it needs to be. If it’s a teenager and she’s approaching puberty, all of a sudden I’ve got a different weight ratio than when I first did the chair when she was 9. I need to be able to adjust that for her.”

  - **K0005 configurability:** “Kids who have been full-time chair users just about from birth have a different trunk-to-arm ratio than an adult who starts using a wheelchair. Their arms are long relative to their trunks in a lot of cases. When you’re not weight bearing, your trunk doesn’t tend to grow as much. Think of a lot of kids with spina bifida: They’ve got short trunks. But their arms are normal length, so you really need to accommodate for that.

  “The basic setup on most chairs K0004 and lower don’t allow me to put the height and the forward/rearward of the wheel where I need it to be.”

- **Environment:** “We’ll talk about school, especially if it’s a kid who needs to change classes, if they’ve got long distances. Some high schools have campuses, and we will certainly discuss that with payor sources.”

- **Learned helplessness:** “In order to get rid of it, I’ve got to make the kid functionally and efficiently mobile by the age of 4, is what all the research tells us. With everything I do, I’m not just focused on today. I’m focused on 10 years from now. So when I think about learned helplessness and I think about how that kid is not as high an achiever at school, is not going to do as well on a job, that’s of paramount importance, to get that functional, efficient mobility.”
As an example of such data, Srinivasan adds, “The simplest example of performance data is how much force a person is exerting on the handrim to propel their wheelchair at a functional speed. Tools such as the SmartWheel provide that data in automated reports that are easy for clinicians to include in their justifications. It’s important to show with hard data that ultralightweight chairs really do reduce the amount of force that chair users need to exert to go about their activities of daily living.”

If the seating & mobility team doesn’t have access to equipment such as the SmartWheel, Srinivasan says there are other ways to gather useful, objective data: “Even without high-tech tools, clinicians can use basic observational tools — for example, count the number of push strokes needed to cover a certain distance — that will provide data to support their claims. A lower number of push strokes to cover the same distance in a similar time is also an indication of less exertion with an ultralightweight chair.”

Funding sources also want to see data supporting the client’s ability to successfully use that ultralightweight chair in the first place.

“Does the beneficiary have sufficient upper-extremity function to propel a manual wheelchair?” Brown asks. “It’s imperative that clinicians and ATPs document limitations in strength, endurance, range of motion, and I mean the numerical strength testing and range of motion testing. Funders are wanting to see documented the objective data to support their claims. A lower number of push strokes to cover the same distance in a similar time is also an indication of less exertion with an ultralightweight chair.”

Powerful Prerogatives

Not all of the latest technological advances for ultralightweight manual chairs involve the engineering of titanium or aluminum. Several recent innovations, in fact, give ultralight users some literally powerful new options.

**Max Mobility’s SmartDrive** power-assist system is motion activated. Once the system is installed, the ultralight user pushes his or her chair’s pushrim to start the SmartDrive rolling. The system continues to propel the chair at that speed — the user can increase speed by pushing the pushrim again — until the consumer stops the chair in the usual fashion.

SmartDrive can be turned on and off with the touch of a button — which is recommended during certain maneuvers, such as rolling down ramps or performing wheelies, to ensure the unit isn’t inadvertently activated by pressure on the pushrims.

The SmartDrive unit (weight = 11 lbs.) attaches to the wheelchair’s axle hitch, while the battery unit (8 lbs.) slides under the seat. The system focuses on giving consumers an instant “power boost” whenever and wherever they need it.

Spinergy’s new ZX-1 power add-on system can be quickly attached (and detached) to most rigid manual chairs. It fits chairs with widths of 15-20” and rear wheel sizes of 24”, 25” or 26”. The ZX-1 system includes a joystick that mounts on the right or left side, effectively turning an ultralight chair into an on-demand power chair while retaining the chair’s inherent maneuverability.

The ZX-1 also includes two 12v 15-amp batteries that produce a 4-mph top speed, Frog Legs forks, removable handlebars with arm pads, and a carbon fiber motor cover to keep the system’s weight down. Spinergy touts the ZX-1 as a way for ultralight users to cover longer distances while expending far less energy than they would if they self propelled, while also being able to detach the system when it’s not needed.

**Putting It All Together**

Once the seating & mobility team has gathered all this information, from the potential clinical benefits of using an ultralight chair to the subjective and objective data that supports that opinion, it’s time to put it all together into a claim that will tell your story.

As you bring the pieces together, Brown suggests starting at the start.

“The original definition of assistive technology really came before the Medicare Modernization Act of 2003, before the Mobility Assistive Equipment guidelines, before we started to talk about
Funding Series

Justify It! Ultralightweights

MRADLs,” she says. “We used to talk about prescribing assistive technology as the most simple, least-costly alternative. As we evaluated the patient and found more limitations or more issues, then we would start looking toward the more complex, more expensive equipment.

“Clinical problem-solving is something we all do, and as we adapt to the new funding rules, it’s more important than ever for us to be able to paint that picture for the payer source so they understand how we came to our equipment selection. The bottom line is even though you can state those outcome findings or objective measures, you must always tie it back to how it will affect the patient’s ability to perform their routine activities and their MRADLs.”

“The best form of documentation is a concise, detailed evaluation that explains how the features of a K0005 chair will increase your end user’s ability to complete functional daily living activities,” Boucher says. “Quantitative data such as range of motion, upper- and lower-extremity manual muscle tests, and seating mat evaluation results are critical to share with funding sources so they understand why you are prescribing an ultralightweight frame. Going through the process of ruling out that the end user is able to complete daily activities with the use of a walking device, and/or a lower coded chair, is the best start.”

To be sure, the seating & mobility team creates a lot of pieces of information during the assessment and equipment trials process, and the task of choosing what to include can be intimidating.

“The therapist and the ATP need to work together closely to make sure they include all the relevant information and documentation,” Roesler says. “Sometimes, less experienced therapists can get overwhelmed when participating in wheelchair selection, but the data needed for justification is usually the same data they are using to document daily client goals and gauge outcomes in rehab. They simply need to integrate it as part of equipment assessment. The ATP can help by providing examples of success and helping to narrow down choices once the clinical indications have been identified.”

Finally, don’t let the upcoming documentation process discourage you and your team from seeking the K0005 solution when you believe it’s warranted.

“We want the equipment to become an asset, not a liability,” Roesler says. “Many people are shortchanged, whether it be by diagnosis or perceived funding limitations, and it results in poor outcomes for the client long-term. For example, I have had many therapists tell me that clients with a stroke do not qualify for an ultralight wheelchair. The diagnosis does not, and should not, preclude us from considering an ultralight chair.”

Custom-configured ultralightweight chairs can open new doors of opportunity and ability for consumers — and that potential independence is worth fighting for.

“We need to look at each client individually,” Roesler says. “It might be oversimplifying it, but I truly believe we should not be asking, ‘When should we consider an ultralight,’ but ‘Why shouldn’t we?’ We should give every client the chance and opportunity to have the highest quality of life.”

Yamaha’s Next-Generation Power-Assist Readies for U.S. Debut

At Medtrade in October, Yamaha Motor IM America — which has manufactured manual wheelchair power-assist units for years — gave attendees a sneak peek at a pair of new power systems for manual wheelchairs.

The JWX-2 power-assist unit has a new, flatter design that Yamaha says enables the unit to be fitted to just about any manual chair. Business Unit Manager Joe Klickna adds that the JWX-2 uses the chair’s original axle plate with a simple adaptor, and that axle position and center of gravity can be adjusted.

In addition, Yamaha’s JW SmarTune software gives clinicians the ability to measure the wheelchair user’s propulsion abilities and efficiency and make adjustments as needed.

For example, if the consumer has less strength in one arm than the other, the software can fine-tune the JWX-2 to compensate and balance, so the consumer moves in a straighter line with less need for course corrections.

The JWX-2 can also be set for more or less power assistance, and for higher or lower turning sensitivity.

Klickna says the JWX-2 data collected via the SmarTune software can be used by ATPs and clinicians to detect not just uneven arm strength, but also stroke frequency and distance, how long the consumer is touching the pushrims, and whether one arm shows fatigue more quickly than the other.

“You can also easily compare assisted vs. unassisted propulsion to really show how much improvement the power-assist is adding,” Klickna says.

And the JWX-2 isn’t the only new innovation from Yamaha’s Intelligent Machinery Operations division.

The manufacturer also showed off the JWX-1, an add-on power unit for manual wheelchairs. The system consists of two wheels, each containing a motor, plus a joystick, a battery and a charger. An optional attendant controller is also available.

For portability, the wheelchair retains its foldability with the JWX-1 in place, and the wheels have a quick-release design. The system weighs less than 33 lbs. without the battery, and is capable of a top speed of about 3.75 mph.

Yamaha says tens of thousands of JWX-1 units have been used in Japan. As for the JWX-2, look for an early-2014 launch in the United States.

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Assistive technology professionals who introduce young children to independent power mobility often face multiple obstacles in their path. Yes, there is the usual equipment evaluation — gathering accurate measurements, factoring in growth, determining which seating, positioning and mobility products are the best fit. But in addition, there are others who need to approve of the idea: parents, for sure, but also funding sources.

Payors have historically been reluctant to support power wheelchairs for some of providers’ and clinicians’ youngest clients. Many funding source objections are based on issues of safety — Can a very young child be a safe driver? — or whether putting an infant into a power chair yields any benefits, particularly if the child doesn’t operate the chair very fluidly.

While safety is a valid and important concern, so is the child’s cognitive, social and emotional development, which leads clinicians to respond with their own question: Can we afford to wait to give a child the chance to become independently mobile?

The Argument for Early Intervention

Ask healthcare professionals at what age a child should be given the chance to operate his or her own power chair, and you’ll get a variety of answers, especially with those not intimately familiar with the seating & mobility niche. But ask parents at what age a baby starts to achieve some mobility, and they’ll note that rolling and crawling usually happen within the child’s first year, with walking — either independently or while hanging onto furniture — not far behind.

If those are developmental mobility milestones for typically developing children, should it be any different for children with special mobility needs?

“We can remind ourselves as well as the families of the children with whom we are working that between three and 13 months of age, infants undergo three periods of profound changes in perceptual, cognitive and socio-emotional behavior,” says Sharon Pratt, PT. “Findings from over two decades of research demonstrate that an infant’s newly acquired ability to move independently through...
Pediatrics Series

Early-Intervention Power

At first, children need a large, open, safe space where they can learn to control direction and just explore — Sharon Pratt

space is a powerful facilitator of a number of developments that occur during these times of behavioral reorganization.

Pratt points out “three significant times of mobility development”. When infants start to reach (typically between three and four months of age), to creep (typically, seven to nine months old), and to walk (typically at 12 to 13 months).

“Locomotor experience facilitates psychological development,” Pratt says. “With this in mind, children ideally should be allowed to meet recognized milestines, even if modified.”

Maggie Love, OTR, clinical education specialist at Permobil, says of this important time in a child’s life, “While the brain has shown neuroplasticity throughout the lifespan, it is less able to change after critical periods of development have passed.”

Love cites a study (Stiles, 2000) that contends that active experiences are crucial for brain development.

“It is during this time that the brain is developing motor and sensory neural pathways required for cognition and language development,” Love says. “Consequently, a moderate mobility impairment can cause impairments in language, vision and intellect.”

So, mobility is more than just an accomplishment for a growing child; it’s also the way that children learn.

“Mobility helps with other skill acquisition,” says Doherty, OTR, ATP/SMS, regional manager for Quantum Rehab. “It also helps in prevention of learned helplessness, which is difficult to overcome once it has been established.”

Pre-Requisites for Power

Once the child’s healthcare team decides to assess for power mobility readiness, what cues should they be looking for regarding the child’s skills and abilities?

For instance: A comprehensive understanding of cause and effect — I push this button, and my chair moves! — has been considered by some clinicians to be the acid test when deciding whether a child can successfully and safely operate a power chair. But is that a fair requirement to demand of toddlers and infants?

While Doherty says understanding cause and effect is necessary for the child to understand that he is controlling his wheelchair, he says, “When we are talking about very young children, we have to be careful with the requirements and be sure that the requirements are age appropriate. A 2-year-old may have an understanding of driving a power chair, but still requires supervision, as with any toddler.”

Therefore, Doherty wants to “see the beginnings of understanding that they are moving the chair through space. Other skills such as safety while driving will develop over time.”

“As a therapist with much less experience with children many years ago,” Pratt says, “I used to think that children would need to at least be able to use switches or joysticks with toys or computer-type devices first. But I have since learned through experience as well as from reading others’ experiences and research that young children learn cause and effect and direction more easily in power mobility because it provides more sensory experience. In other words, allow the child to sit in a power wheelchair and develop their cause-and-effect skills!”

Love emphasizes that very young children may need time to fully understand and explore the cause-and-effect concept.

“A child who understands cause and effect may be more likely to have a better experience in learning power wheelchair mobility,” she explains. “That is, if a child can understand that when her hand touches the joystick, the chair moves, there is a greater likelihood that this would help a child generalize this to facilitate further success. It is important to note that finding that control site may take several sessions and various trials with different equipment. Trial of the equipment is vital to determining if someone might be a candidate for power mobility, as is continued training.”

Ever-evolving electronics technology can help young children with another power chair requirement. Having dependable and functional control over some part of the body that can be used to drive.

“We have to remember that any part of the body where we can mount a switch can be used as an access point to control a power chair,” Doherty says.

“There are lots of ways for young children to use power wheelchairs,” Pratt agrees. “Joysticks are common, but there are many switches and other special controls. Some children use their hands, and others may do very well using their head, feet or a combination of body parts.”

“I remember working with a little boy many years ago,” Doherty says. “He was 3 when I met him and he was very smart, but only had one consistent movement. I educated his mother and father that he could still drive a power chair with that one movement. They were surprised because they thought he had to be able to use his hand to control a power chair. Education was all that was needed.”

Regarding other factors that can shape a child’s power mobility experiences, Love says, “Problem-solving skills, understanding spatial relationships and cognitive developmental abilities influence a child’s potential for successful independent power mobility; however, these very skills can develop through the use of powered mobility.”

And Pratt says, “I personally do not believe that there are developmental or cognitive pre-requisites for young children and power mobility. I think it is way more important that we introduce the mobility to the child and their environment in a way that the child can immediately begin to manage it, because it is through the use of mobility/locomotion and discovery that development can progress.”

The Importance of Following Directions?

A common concern among parents — and sometimes among clinicians as well — is that infants and toddlers trying out power chairs don’t always obey directions such as “Slow down” or “Stop!” If a child doesn’t consistently listen to grown-ups’ commands, is that a deal-breaker?

“I believe the child has to be safe in the wheelchair with supervision,” Doherty says. “The basic ability to follow simple directions is important, but if more time is needed for them to develop this skill, I believe a longer trial period may be necessary.”

And Doherty says pausing to consider how able-bodied children behave can help parents and the mobility team keep a valuable sense of perspective.

“I think back to my own children and how many times I told them...
to stop or slow down, and how often they didn’t listen,” he says. “It was an opportunity to ultimately teach them a lesson. We have to keep in mind that children who have a disability that has prevented them from moving through space have not had the opportunity to ignore an adult, and I believe this is part of learning independence. So, the child will need to learn to listen, but we can only do this if the opportunity arises to teach them.”

“If a child is unable to follow basic directions such as ‘stop’ and ‘slow down,’ that should not disqualify them from having access to independent mobility,” Love agrees. “There are plenty of typically developing toddlers who do not consistently listen to adult directives, even if the adult uses the child’s first, middle and last name.”

Rather than just assuming the child isn’t yet ready for power mobility, Love suggests digging deeper.

“It is beneficial to determine the reason that the child is not following verbal directions: a behavioral issue, motor-planning issue, spasms or primitive reflexes, or perhaps an auditory-processing issue? Depending on the reasons, different interventions are warranted. Case studies have found that there are improvements in receptive language skills and overall development with access to powered mobility.”

And Pratt recommends against stifling a child who is just learning the joys and possibilities of being able to move on his own.

“Children learn best through play and exploring for themselves,” she notes. “Too many verbal directions can be confusing, distracting and create fear. They are not like adults learning to drive a car, for example. At first, children need a large, open, safe space where they can learn to control direction and just ‘explore.’ A great example is chasing balloons in an open, safe environment. Sometimes power mobility toys can be easier for very young children to experience the concept of locomotion with power at first. Once children have learned to control direction and to stop in a safe environment, they are then most likely ready to progress to other places. It needs to be recognized when going through this experience that the young child needs to explore mobility first, not ‘driving.’”

**Early Intervention for Eventual Ambulators**

Traditionally, power chairs have been considered as mobility solutions for young children who are unlikely to ever functionally ambulate. But could power chairs also benefit children — such as those with Down syndrome — who probably will learn to walk, but will do so much later than typically developing children?

“Yes, absolutely yes,” Love says. “Introducing and assessing for powered mobility at an early age is worthwhile if you feel that the child will not be able to efficiently ambulate in all age-appropriate environments before the age of 4. They should be considered for power mobility.”

The reason? “Exploration of the environment is an important mobility management | January 2014 21

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**Power Mobility: Getting Parents Onboard**

Parents of a child being assessed for a power chair often have to work through conflicting feelings. They want what’s best for their baby, but may cling to the hope that their child will walk one day. They may be intimidated by the size and weight of a power chair and worry about their child’s safety.

ATPs and clinicians, therefore, are faced not only with teaching a very young child to operate a power chair, but also with educating their parents. Some tips from clinicians who’ve worked with young children:

- **Emphasize the power of independent mobility.** Sharon Pratt, PT, says, “I believe in taking away some of the fears that parents have with regard to the idea that ‘if my child uses a power chair, this is disabling and maybe they will therefore not walk’ — which of course is what every parent wishes for their child — and instead emphasizing the powerful message that motor skills do not decrease when children use power mobility. Share the studies that show better use of motor skills, increased motivation in therapy, and improved cognitive development.”

- **Reassure parents that the team and child can work on both power mobility and walking.** “We need to let parents know that just because we are working with a child and power mobility doesn’t mean he or she has to give up on ambulation and standing activities,” says Jay Doherty, OTR, ATP/SM. “Many children need both.”

- **Explain the definition of independent, functional mobility.** Maggie Love, OTR, says, “It is important to talk to the parents about the difference between therapeutic ambulation/exercise and functional mobility. Just because a child may be able to ambulate short distances with a walker or manual mobility device does not mean that it is functional. It should be relatively effortless for a child to move in their environment. Children with disabilities, just like their peers, need cardiovascular exercise. Exercise, by definition, is tiring. We ourselves make the distinction between exercise and mobility.” She suggests painting that picture for parents: “Can you imagine if you jogged everywhere? How tired would you be? How much would you be able to concentrate on work/school?”

**Address their safety concerns.** A child learning to use a power chair will bump into things — accidentally, and maybe even on purpose — as part of the exploration process. Remind Mom and Dad that typically developing children are no different. “When a child begins walking, he or she may walk into something in a room, not paying attention — that’s part of learning about moving in their environment,” Doherty says. “Children in wheelchairs need the same opportunities.”

Love adds, “Of course, safety measures such as a remote stop switch and an attendant control should always be considered for children in the midst of power mobility training.”

And when those wheels inevitably meet that solid object (again!), Love suggests the kind of encouragement parents would give if the child were learning to walk.

“When considering verbal directives,” she says, “provide positive feedback: ‘you found the table!’ versus ‘you crashed!’ And try and suggest things (‘lift your hand off’) — rather than issuing commands (‘Stop’) (Jones et al., 2003).”
Early-Intervention Power

Component in a child’s development,” she says. “Even if the child is expected to eventually ambulate with or without assistive devices, providing access to mobility to keep up with typically developing peers is vital to ensure that developmental milestones are reached. I have heard from some parents that they are concerned that providing power mobility will slow down their child’s desire to ambulate — however, the research says the opposite, that access to mobility may actually improve the child’s motivation to participate and use their trunks and hands to explore the environment.”

Of these children with mobility delays, “Mobility provides learning opportunities for developing skills,” Doherty says. “Providing a power chair as early as possible can assist with development of skills that may be further delayed if mobility opportunities are not provided early on.”

While payors may not always be enthusiastic about providing a power chair to a child expected to eventually learn to walk, Pratt agrees that doing so is important.

“Research has shown that motor skills do not decrease when children use power mobility,” she explains. “Some studies have shown better use of motor skills and increased motivation in therapy as a result of using power mobility. It is well documented that the early use of power mobility can help the young child’s development and learning.”

“In my opinion we don’t always know what the potential is for the child down the road in terms of what skills they may or may not develop when they get an opportunity to use power mobility at an early age — but we do know that in the absence of locomotion/mobility/ability to move around in their environment, the child’s development is truly vulnerable in all areas: cognitive, social, emotional, visual-perceptual, intellectual and language. So yes, in my opinion it is worth providing power mobility access to these young children who otherwise cannot explore their world at an age-appropriate time.”

Driving with Supervision

The same goes for children capable of operating a power chair only under controlled circumstances — such as while in wide-open spaces or while being closely watched by a grown-up.

“I still believe that providing the chance to move through space is important for development, even if supervision is required,” Doherty says. “Providing mobility opportunities enhances development of perceptual and cognitive skills that will influence other parts of the child’s life.”

As a result, it is worthwhile to provide a power chair to a child who may never be able to drive with complete independence, Love says, “I do believe in many cases the answer is yes, it is important to utilize a power chair therapeutically. Our visual systems don’t develop as well with passive movement as they do with active movement.

“Think of travelling to an unfamiliar location and a friend drives you. Would you be able to navigate your way back? It is the same concept for a child being passively pushed to a classroom. They will not develop the same navigational skills. Even for children who will always need supervision, there can be improvements in cognition, visual development and participation with access to mobility — in fact, this could be their only chance to explore their environment to develop those skills.”

Giving Every Opportunity to Every Young Child

Ultimately, the most beneficial rule of thumb may be to focus on the usual developmental milestones and time-
tables rather than to concentrate only on a particular child’s challenges. “It is important that we consider the ‘normal’ developmental milestones,” Pratt says. “In the usual sequence of events — from ‘rolling’ to ‘sitting’ to ‘crawling’ to ‘pulling to stand’ to ‘cruising’ to ‘walking’ — babies move through these developmental stages almost seamlessly. I believe we should never lose sight of the fact that all children, regardless of ability, should be allowed to meet recognized milestones, even if modified.”

“We need to prescribe power mobility more often and start earlier in the development,” Love says. “Educate the parents and caregivers. ‘We are just waiting till they are in school’ is not an appropriate excuse. We need to include very involved children as well as children who are using walkers/manual mobility devices inefficiently. The RESNA position paper on Application of Power Wheelchairs for Pediatric Users is available for free online and is a comprehensive peer-reviewed review of current research.”

Love adds that children being considered for power mobility shouldn’t have to demonstrate perfect skills to qualify, but rather should be given the opportunity to learn them.

“According to Medicaid, we are determining if the individual has the capacity for independent mobility,” she says. “Training is a vital component in prescribing power mobility in children, especially at younger ages. Studies suggest that daily practice with a trained caregiver is needed (Jones et al., 2003). An hour, once a week simply is not enough.

Learned helplessness is difficult to overcome once it has been established

— Jay Doherty

“The skills/abilities needed to trial use of a power mobility device do not need to be fully developed. Oftentimes, they are not. For example, just because a child may not consistently use a switch to operate a toy or computer program does not automatically determine that they do not have the capacity for learning cause and effect. The visual, tactile and vestibular inputs from driving a power chair are vastly different from an abstract computer game and may be more motivating for the child.”

Educating parents about these facts can help them to see a power chair as an “enabling” tool rather than a sign of their child’s disability, Pratt says. And when that change of mind and heart happens, the rewards can be overwhelming.

“There is no greater gift for a family than to see their child with special needs playing and exploring alongside their siblings or other young peers in a playground, regardless of the locomotion method,” she says. “This positive experience can make a world of difference with regard to how early in that child’s life a family will be open to the possibility of accepting power mobility.”

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In the end, they were ignored: The final rule for recategorization of DME and complex rental products was published virtually intact from the proposed rule despite the Centers for Medicare & Medicaid Services (CMS) receiving 172 public comments from a range of stakeholders that included consumer organizations and Veterans Affairs.

The final rule, CMS-1526-F, was published Nov. 22 and reclassifies as capped rental a list of items previously “routinely purchased.” The list includes a large number of complex rehab technology (CRT) products.

In informing members of this development, Don Clayback, executive director of NCART, said in a Nov. 25 bulletin, “Back in August, NCART submitted comments, along with many other advocacy and industry groups, to the proposed rule identifying major problems. Our comments included very specific recommendations and changes. Unfortunately, CMS did not make any substantive changes.”

Adult Tilt-in-Space Now a Capped Rental

In determining whether DME would continue to be routinely purchased or moved to the capped-rental category, CMS used its purchasing data from 1986-87.

CMS noted that if a product was purchased by Medicare at least 75 percent of the time during 1986-87, the product would remain in the purchased category. But if the product was purchased less often than 75 percent of the time in 1986-87, the product would be reclassified as capped rental, with Medicare paying the provider a rental fee for 13 months. After 13 months, the equipment would officially belong to the beneficiary.

Critics objected to CMS using such old purchasing data in part because newer types of technology didn’t exist 26 years ago and therefore would automatically be defined as being purchased less than the required 75 percent at that time.

That includes adult manual tilt-in-space wheelchairs (HCPCS code E1161).

Pediatric Chairs Also Affected

Another category of concern is pediatric chairs, coded E1232-1238.

Commenters noted that children needing pediatric wheelchairs have severe and permanent disabilities and would need the chairs on a long-term basis.

But much as with the adult tilt-in-space category, CMS brushed that argument aside, this time saying that 1986-87 data — using the pediatric wheelchair code in effect at that time — showed that pediatric chairs weren’t purchased often enough to be considered routinely purchased.

The Industry’s Next Steps

“We’re very disappointed with the complete lack of attention to the comments made by all the stakeholder groups,” Clayback said in a Mobility Management interview. “(CMS’s) basic message was, ‘We’re going to rely on 26-year-old data, and we’re really not going to listen to the concerns of people who are impacted by this.’

Clayback said NCART had been hoping at the very least for CMS to pause and “work to create a more rational way to classify capped-rental items.”

Instead, the new policy goes into effect on April 1, 2014 — with later implementation for products currently part of the Medicare national competitive bidding program’s round 2 or round 1 rebid.

Given that CMS did not incorporate the public comments they requested into what stakeholders now view as a very flawed final rule, the question is how the industry will respond.

Clayback says stakeholders plan to reach out to Department of Health & Human Services Secretary Kathleen Sebelius, and also to talk to members of Congress, who have stepped in before.

“Congress weighed in back in 2010, when they looked at power wheelchairs and said, ‘We’re thinking of making all power
wheelchairs rental,’ and our community pointed out the problems with doing that to complex rehab,” Clayback says. “Congress said, ‘All right, we’re going to make standard power wheelchairs capped rental, and we’re going to make complex rehab power wheelchairs routinely purchased.’ We mentioned that in our comments, but that’s another example [CMS] completely ignored.”

Adopting New Strategies?
While educating payor sources has long been the CRT industry’s mantra, Clayback indicated that may be changing when it comes to Medicare.

“As CRT advocates, we’ve been doing a lot of education over the years about what complex rehab technology is,” he notes. “While I do think more education needs to be done in certain segments, I feel comfortable saying that CMS does understand what complex rehab technology is. They’ve chosen not to use that understanding to amend their current policies. When we’re talking about Medicare and the policy people, I think they’ve gotten more than enough education.”

Instead, Clayback says, “I think we need to redefine the issue, which is not that CMS doesn’t understand what CRT is, but they don’t want to be responsive to the needs of those individuals — which to me is a significantly different issue. What is the agenda here? Is the agenda to make these changes to eliminate access to specialized equipment? In other words, ‘Everybody’s just going to get a standard wheelchair, and we don’t want to deal with specialized equipment’? If that’s the decision, I would argue that’s CMS not living up to their obligation, which is to provide appropriate coverage to the Medicare beneficiary. That’s where you get into this bigger question of how they’re carrying out their responsibility to both protect the program and to protect the beneficiary.”

In addition to reaching out to Congress and to Secretary Sebelius, Clayback says NCART is looking at revising the Medicare separate benefit category language that currently exists in bills in the U.S. Senate and House of Representatives.

“We’re setting up meetings with our sponsors on both the Senate and the House sides to explain this new event and what the issue is and then discuss how this could be incorporated into our legislation,” he says.

At press time, these multiple efforts were underway, despite the fact that final rule implementation won’t start till spring. “Even though they’ve delayed [implementation] till April 1, with rehab products, what you’re delivering in April is what you’re evaluating today,” Clayback points out.

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P326A Vision Sport

The K0833/822 power chair has a full suspension and a 300-lb. weight capacity, with dual inline motors for enhanced efficiency, torque, range and performance. A swing-back joystick mount is standard. Other features include height- and width-adjustable arms, semi-reclining back, and 10" solid tires for the drive wheels. Optional accessories include elevating legrest, oxygen tank holder, cane/crutch holder, foldable rear basket and canopy.

Merits Health Products
(800) 963-7487
meritshealth.com

BOSS 6.75

Despite its 675-lb. weight capacity, the BOSS 6.75 is still nimble indoors, with a 27" turning radius, and offers an extra-low seat height (17") for better access to tables and desks. Outdoors, the 180-amp module controller and 1.75-hp inline drive supply great range (18 miles) and power (climb an 8°, 140-yard hill 20 times). The step-on footrest facilitates transfers. Features 50° of recline.

PaceSaver/Leisure-Lift
(800) 255-0285
pacesaver.com

M300 Corpus HD

Designed especially for consumers weighing up to 450 lbs., the M300 Corpus HD has a mid-wheel-drive configuration for maneuverability, and extremely sturdy armrests and legrests to support users’ active lifestyles. The chair also features power tilt (0-45°) and power recline (90-150°), along with an extra-wide footplate and durable mesh upholstery to keep moisture away from the user’s body.

Permobil
(800) 736-0925
permobil.com

Jazzy 600 ES

Available with Synergy rehab seating, the Jazzy 600 ES features Mid-Wheel 6 ATX suspension, 2-pole motors, 50-amp electronics and NF-22 batteries. It comes standard with a 4-mph top speed, a 300-lb. weight capacity, and red shroud with black drive wheels and casters. The caster design helps to prevent hang-ups and optimize obstacle climbing. With a K0822 code, the Jazzy 600 ES is designed for consumers needing static complex rehab seating with a versatile power base.

Pride Mobility Products
(800) 800-8586
pridemobility.com

Quickie QM-710

The Group 3 QM-710 has Spider-Trac suspension, an intuitive mid-wheel-drive base, PG Drives electronics and comprehensive power seating options, including tilt, recline, elevate and articulating/elevating legrests. The 12" seat lift gives its user eye-level interaction and greater access to the environment, but seat heights as low as 16" are compatible with tables and desks. With a 300-lb. weight capacity and standard 6-mph top speed.

Sunrise Medical
(800) 333-4000
sunrisemedical.com

PG Drives Technology

The R-net for Android app (free download from the Play Store) can give power chair users control of their smart devices via R-net joysticks or specialty controls connected to the Omni. The app places a cursor on the device’s screen, and moving the joystick navigates the cursor. Joystick clicks or nudges can open applications. The app contains configuration options.

PG Drives/Curtiss-Wright Controls Industrial
cwc-ind.com

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**Product Revue**

**Foot Platform Options**

Motion Concepts, a manufacturer that lives to create one-of-a-kind seating & positioning components for the most difficult-to-fit clients, was at Medtrade in October with its usual array of innovations. I’ve always had a special fascination for the company’s many foot platform options, which now include center-mounted power platforms that flip up to ease transfers; that articulate; that function as lifting platforms; that lower all the way to the ground. Plus, Motion has an array of one-piece calf panels or two-piece calf pads to offer additional support. So much investment in a part of the seating system that often gets upstaged by flashier components... but not at Motion Concepts. — Laurie Watanabe

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motionconcepts.com

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**Strae Handcycles**

Designed for a safe, ergonomic and highly competitive cycling experience, Strae Handcycles — a division of Freedom Concepts — are described as “lifestyle inspired.” The Grizzly Cruiser Bike is pictured, but other models include Totally Neon and Midnight. Options include seat covers with custom graphics, upgraded shifter knobs and carbon fiber rims. The seat back goes from 40° recumbent to 90° upright (and anywhere in between), and the bottom bracket system allows for within-the-inch crank positioning for the best possible propulsion power.

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**Kimba Kruze Stroller**

The new Kimba Kruze has plenty of features for kids, including footrest options; a height-adjustable and foldable footrest; backrest and height extensions to grow as kids do; two positions for backrest angle adjustment; and a comfortable five-point padded harness. But it’s also designed to be easy to fold and store for transport, thanks to the Kruze’s light weight and low profile. The stroller is for kids weighing up to 165 lbs.

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**Spitfire Scout Series**

This new series of three- and four-wheeled scooters was created to be compact and conveniently portable for consumers on the go. The lightweight scooters are easy to disassemble into five easy-to-handle pieces. The color-through panels hide scuffs and scrapes on standard models; the DLX models have high-gloss color panels, metallic wheel rims and two-tone seat upholstery.

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**Quantum Securement Station**

Wheelchair securement has a new look! Q’Straint’s Quantum is a fully automatic rear-facing securement system for wheelchairs that board buses or other commercial vehicles. After boarding the vehicle, a wheelchair user can push a button to correctly position his or her chair and secure him/herself in a safe rear-facing position without requiring driver assistance. Q’Straint says the process takes 25 seconds, with Quantum’s arms securing the wheelchair (or scooter) by holding its wheels and adjusting its grip during the ride.

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